CARES Realignment Study October 23, 2003

VISN: Northwest Network, VISN 20

Facility Name: VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. (692)

Affected Facilities: White City, Roseburg, and American Lake

A. Summary and Conclusions:

a. Executive Summary:

Recommendation: Maintain current programs at White City similar to the initial VISN20 Market Plan. Building demolition occurs on an accelerated timeline with greater space reductions and more aggressive enhanced use leasing.

The VA Southern Oregon Rehabilitation Center and Clinics (SORCC) offers high quality, low cost biopsychosocial rehabilitation services located in a residential therapeutic community. These services are designed to restore patients to their highest levels of functional independence and health, thus enhancing quality of life for veterans with a history of homelessness, substance abuse, and/or other psychiatric illness by meeting medical, psychological and social needs. The facility also offers a full range of outpatient services including primary care, specialty care, mental health, and ancillary/diagnostic support.

The recent name change from VA "Domiciliary" to VA "Rehabilitation Center" reflects the dramatic mission enhancements implemented at White City over the past three years. As a JCAHO and CARF accredited organization for Behavioral Health Care, White City SORCC has pioneered a full array of biopsychosocial rehabilitation programs with outcomes unparalleled in VA or private sector. In the context of this realignment analysis, the term "Domiciliary" is utilized only to conform to the CARES terminology and is not considered an accurate descriptor of the VA SORCC mission.

The Draft National CARES plan proposes to transfer the White City SORCC biopsychosocial rehabilitation programs and associated residential beds to another VAMC in VISN20. White City is to maintain outpatient services. The alternatives analyzed in this realignment study are summarized as follows:

- **Status Quo:** Maintains the residential beds and outpatient workload on the White City campus in the existing buildings.
- **VISN20 Market Plan:** Accommodates the CARES projected demand for inpatient and outpatient services at White City SORCC. The VISN20 plan proposes four minor construction bed building replacement projects and a modest outpatient clinic expansion. The VISN20 Market Plan emphasizes campus realignment through *long-term* footprint reduction and enhanced use leasing.
- **Contracting:** Assumes, for purposes of the cost analysis, that all inpatient care can be contracted. Maintains outpatient services on the White City campus.

- **Alternative #1- American Lake/Medford:** Closes White City SORCC campus, moves all residential beds to a new structure at American Lake and moves outpatient clinic to Medford.

- **Alternative #2- Roseburg/Medford:** Closes White City SORCC campus and moves all residential beds to a new structure at Roseburg and moves outpatient clinic to Medford.

- **Alternative #3- Rapid Footprint Reduction (preferred):** Maintains current programs at White City similar to the initial VISN20 Market Plan. Building demolition occurs on an accelerated timeline with greater space reductions and more aggressive enhanced use leasing.

VISN20, White City, and stakeholders testifying before the CARES Commission, are in full accord with the concept of maintaining an inpatient presence rather than relocating all of White City's beds to either the American Lake campus or Roseburg campus. Though the original market plan has the best NPV, White City was asked to evaluate other options. The Rapid Footprint Reduction (Alternative #3), with the second best NPV and the best life cycle costs, ensures continuation of high quality rehabilitative care for a special emphasis veteran population, and minimizes disruption to staff, affiliations, and community.

b. Current Environment:

The SORCC is located in the fastest growing (1.1% per year total population) urban metropolitan area in the State of Oregon. Veteran population in Jackson County is projected to increase during the CARES planning cycle, which is in contrast to most other counties in the Network. The SORCC includes 62 buildings representing 734,345 DGSF on 145 acres. The outpatient clinic is in good condition but requires a modest expansion to accommodate the projected increased workload. The inpatient buildings have been renovated to various degrees and are well maintained. Seismic concerns exist in relation to the bed buildings due to the un-reinforced masonry construction.

c. Workload Summary:

The following table summarizes inpatient bed levels and outpatient visits.

Workload or Space Category	Baseline Wkld	Baseline workload from Millman for beds & stops	2012 projected Wkld	2022 Projected Wkld
Inpatient Medicine		1	1	1
Inpatient Surgery		1	-	-
Inpatient Psych		-	-	-
Inpatient Dom	727	727	727	727
Inpatient NHCU		11	11	11
Inpatient PRRTP		-	-	-
Inpatient SCI		-	-	-
Inpatient BRC		-	-	-
Outpatient Primary Care		34,705	41,072	33,268
Outpatient Specialty Care		7,181	30,916	27,023
Outpatient Mental Health		18,789	20,131	19,584
Ancilliary & Diagnostics		42,116	38,169	33,391

d. Proposed Realignment Considerations:

Location and Volume of Care:

The preferred realignment alternative is to implement the Rapid Footprint Reduction and continue the rehabilitation programs at White City. The CARES workload projections for White City VA SORCC beds for 2022 is currently listed at 727 beds. This projection appears to have been derived from the FY 2001 average daily census (ADC) of 691 at 95% occupancy rate.

White City's actual ADC in FY 2003 was 515, an increase of 26 over its FY 2002 ADC. The lower FY 2002 ADC was a result of a planned redirection of staff resources to promote a transition to dedicated case management and a more focused and intense approach to clinical programming. The average age of patients admitted is only 50 years which lends credence to the long term CARES planning strategy for continuation of Domiciliary services. SORCC treated 1,226 inpatients during FY 2003.

A need for biopsychosocial rehabilitation beds is still very apparent in the southern Oregon location of White City. Though it is difficult to ascertain the actual prior residence of "homeless" veterans, admissions data reveals that 69% of inpatient admissions to White City come from within VISN 20. At a CARES public hearing, VISN 21 representatives stated their referral capability (92 veterans in FY 2002) for certain special needs veterans will be adversely affected if the White City campus discontinues inpatient biopsychosocial rehabilitation services. Stakeholders have expressed concern from both northern Nevada and northern/central California that they would be losing a valuable resource referral if White City were to be realigned/closed. In all, 87% of all admissions come from within VISN 20 and northern Nevada and northern California (449 of the 515 ADC).

White City currently maintains 86 Health Maintenance patients who have a length of stay greater than 3 years. Assuming the flat lined 727 bed projection includes all domiciliary bed needs, then it is also assumed between 80-100 beds should be considered long-term Health Maintenance (maintain function and prevent decompensation) in keeping with the VA desired intent to treat Health Maintenance patients - expressly written in M-5, Part IV, Domiciliary Care Program.

An aggressive rehabilitation focus would continue for all other beds at White City versus the small number of Health Maintenance beds. The projected length of stay would be 120 – 210 days. Currently White City experiences an average length of stay at 208 days when the Health Maintenance patients are excluded. White City's treatment philosophy to actively engage its veterans in psychosocial development would continue, via experiential learning, mental health, day treatment, dedicated case management, employment and substance abuse treatment. A continuum of biopsychosocial rehabilitation is occurring where a veteran moves at his own pace, based on his needs and abilities, through major developmental steps towards achieving an optimal level of independence after years of marginal functioning. Achieving long-lasting behavioral changes for this type of chronic population requires a flexible program and cannot be accomplished in the standard 28-day (one size fits all) program. The White City therapeutic community subscribes to and practices a progressive intervention approach between veteran, staff, and community, continuously reassessing the patient in terms of their strengths, needs, weakness, and abilities.

As a variation to the 727 bed flat lined model, the VSSC has recently indicated that the new "domiciliary" CARES workload projection for White City will be approximately 400 beds. Combining these 400 beds with the demonstrated demand from adjacent VISNs, suggests a 500-bed

model. The information presented in the above analysis also supports an operational bed level of 500. VISN 20 would support a 500 bed operational model for White City under the preferred Rapid Footprint Reduction alternative.

Will care be available in the community if it is proposed?

Comparable biopsychosocial care is not available in the communities of White City, American Lake, or Roseburg. The important vocational rehabilitation patient care function currently available at White City would be dramatically reduced if all beds were to be transferred to a rural population with very limited employment opportunities such as Roseburg in Douglas County. Regarding private sector medical care, both Medford and American Lake are urban areas, whereas Roseburg is in a rural location.

How much additional space will be constructed?

Preferred alternative #3 (Rapid Footprint Reduction) will require replacement of approximately 80,000 sq/ft of inpatient bed space (240 beds) at White City, plus 20,000 sq/ft of additional outpatient space. The remaining beds will require varying degrees of renovations as documented by the Facility Condition Assessment completed by GLHN Architects on February 28, 2002. These projects can all be accomplished as either Minor Construction or NRM projects. This new space accompanies a total building footprint reduction of 50% and potential enhanced leasing of an estimated 57,000 square feet and 28 acres.

Alternatives #1 and #2 would both require a major construction project of an estimated 316,282 DGSF at the respective sites (not including administrative support and other space) plus a major outpatient clinic project of 93,820 DGSF located in Medford. Major construction projects require congressional approval for line item funding and are almost impossible to achieve unless the initiative is in a major metropolitan area.

What is the impact on travel time?

Travel time is not considered a major barrier in relation to the inpatient realignments at the White City facility. This homeless population is expected to travel to either American Lake or Roseburg at a similar rate as they had while presenting at White City.

What is the impact on quality?

If services remain at White City impact on quality would be positive. If the biopsychosocial rehabilitation beds were transferred to American Lake or Roseburg, an effort would be required by top management to make biopsychosocial care a facility priority in maintaining a VA model program.

What is impact on the community?

White City has engendered a "therapeutic community" milieu over the past years. It has developed partnerships with the surrounding community, e.g. business and academic affiliates, Stand Down, Pow Wow, Red Cross. The employer partnership for example, has seen almost 200 of White City's veterans placed each year into local companies. Veterans further their employment skills, while productively integrating back into society. In addition, any relocation would result in a profound impact to Rogue Valley citizens, as evidenced by over 900 stakeholders attending the CARES Public

Hearing at the Medford Armory. VA partnerships with the community are built over a period of years and are inherently unique to each relationship.

What is the impact on staffing?

White City employment level is currently 415 FTEE. Over 300 FTEE are costed to the biopsychosocial rehabilitation inpatient bed section(s). Selecting the preferred alternative (Rapid Footprint Reduction) or the VISN 20 Market Plan will not adversely impact staffing. The other alternatives would require significant employee relocation or restructuring. Impact to employees and to their respective families will be major, as many of this facility's employees are life long residents of the Rogue Valley.

What is the impact on Research and Affiliations?

The impact on education/research will be minimal if either the preferred alternative or the VISN 20 Market Plan is implemented. The alternatives of relocating beds to another VISN 20 site would negatively impact affiliations with the Rogue Community College, Oregon Health and Sciences University (OHSU), and Eagle Point High School at the Dom.

Describe the cost effectiveness of the proposal i.e. the costs, savings, and the payback period?

The net present value (NPV) is a primary consideration in any capital investment planning decision. The NPV of the preferred alternative (Alt 3 – Rapid Footprint Reduction) is the most favorable for VA in terms of life cycle costs. Though the original market plan alternative has a higher NPV, the Rapid Footprint Reduction alternative is more appealing than the VISN 20 Market Plan because it expedites the demolition of all excess space to minimize long-term maintenance costs:

Alternative	NPV
Original Market Plan	460,613,883
100% Contract	76,173,906
Alt 1 – American Lake/Medford	84,190,983
Alt 2 – Roseburg/Medford	331,141,640
Alt 3 – Rapid Footprint Reduction	377,831,030

(NPV Values relative to Status Quo – Higher is Better)

As illustrated by the NPVs, any relocation of beds to other VA sites will be more costly. A key cost driver in the NPV calculations is the BDOC costs for each facility; White City has one of the lowest costs per Domiciliary BDOC in the VA.

Capital costs are also expected to be higher for options involving campus closure, as new Domiciliaries and outpatient clinics would have to be constructed.

Briefly describe each of the other alternatives considered and the rationale for not selecting them based upon the analysis of the questions listed?

Selection of the Rapid Footprint Reduction, with the best life cycle costs is the least disruptive and most politically attractive option, with the assumption that the original market plan, with the best

NPV, would not be an acceptable alternative. It makes little sense to place a major biopsychosocial rehabilitation center in a rural area (Roseburg) that does not maintain a significant number of employers for patient placement, or an area of higher seismic risk (VA PSHCS, American Lake Division). It makes economic sense to quickly demolish the existing infrastructure, rather than a protracted demolish and rebuild approach.

B. Analysis

a. Description of current programs and services environment:

The SORCC Domiciliary Program currently provides low cost biopsychosocial rehabilitation services in an inpatient (24/7) setting. These services are designed to restore patients to their highest levels of functional independence and health, thus enhancing quality of life for our veterans with a history of homelessness, substance abuse, and/or other psychiatric illness by meeting medical, psychological and social needs. Services provided by the SORCC Domiciliary Program are grouped into three distinct levels of care:

- Employment services are for the healthiest veterans without significant co-morbid conditions, and include vocational rehabilitation, IT and CWT programs.
- Residential care services are for CMI, PTSD and substance abuse patients, and can include sub-acute stabilization.
- Longer term biopsychosocial rehabilitation is provided for either those veterans failing at lower levels of care and are incapable of living in the community, or for those veterans, coming from 30 day programs at other centers, needing consolidation of gains and continued rehabilitation in a longer term setting.

All of these domiciliary services form a distinct, essential component of the VHA and VISN 20 continuum of healthcare services. The SORCC Domiciliary Program provides a clinically appropriate level of care for homeless veterans whose clinical care needs are not severe enough to require more intensive levels of care.

Initial steps toward an expanded role for the VISN 20 Domiciliaries have already been taken in VISN 20. A Domiciliary Task Force, chartered by Dr. Leslie Burger in FY2003, has developed a plan to integrate all VISN Facility Domiciliary rehabilitation beds by points of contact, and to establish service agreements between SORCC and all other VISN 20 facilities around specific high risk and high need patient populations. There is reason to believe that such proactive non-traditional approaches to care will greatly improve the treatment and outcomes of VISN 20 veterans and is strongly in alignment with VA 2020 patient centric goals.

One hallmark of this patient-centric approach is the belief that care should be as close to home as possible in order to achieve the best outcomes, as well as to ensure maximum patient compliance and convenience. This is clearly valid for acute and most chronic medical and psychiatric conditions. There is no body of literature that demonstrates that outcomes are better closer to home with individuals suffering from severe alcoholism or addiction. In addition, there is no body of literature that states that homeless veterans with co-morbid addictive and psychiatric illnesses receive better care closer to home, when no permanent residence or support structure exists.

For chronically relapsing alcoholic and addicted patient populations, the decision is made whenever possible to remove the patient from local cues and contacts. This is referred to as a geographical cure

in the industry. In managed care environments, such as United Behavioral Health caring for 23 million covered lives, a decision on behalf of a patient who has repeatedly failed lower levels of care is based purely upon quality, not upon location.

In contrast to the Draft National Plan recommendation, we believe the future of Domiciliary care in VISN 20 is in aggressively rehabilitating entitled dually diagnosis veterans, medically and psychiatrically ill veterans, chronic pain patients, addicted and alcoholic veterans with chronic pain, and many other categories of veterans who are excessively accessing medical services year after year, without the typical response to treatment seen in 'normal' patients.

Current Domiciliary programs address the typical wide variety of deficiencies found in the above populations. The SORCC Domiciliary programs are much more than rehabilitation beds. These programs deliver the necessary skill sets and confer lasting motivation to the veteran populations described above. These programs, combined with care management strategies to maximize employment post-discharge, allow for consolidation of functional gains and prevent veterans from disappearing or reverting into a pattern of inappropriate care and services.

The following table summarizes the realignment alternatives:

Alternate # 1	Dom 100%				**Short description**: Close SORCC at White City; move inpatient programs to American Lake in VISN 20; include staff relocation options. Move outpatient services to downtown Medford.			
Workload or Space Category	**Baseline Wkld**	**Baseline workload from Millman for beds & stops**	**2012 projected Wkld**	**2022 Projected Wkld**	**% to be transferred**	**Year to begin transfer**	**Receiving Facility Name**	**Receiving Facility % contracted out**
Inpatient Medicine		1	1	1	100%	2004	Medford (new clinic)	100%
Inpatient Surgery		1	-	-	100%	2004	Medford (new clinic)	100%
Inpatient Psych		-	-	-				
Inpatient Dom	727	727	727	727	100%	2008	American Lake	0%
Inpatient NHCU		11	11	11	100%	2004	Medford (new clinic)	100%
Inpatient PRRTP		-	-	-				
Inpatient SCI		-	-	-				
Inpatient BRC		-	-	-				
Outpatient Primary Care		34,705	41,072	33,268	100%		Medford (new clinic)	
Outpatient Specialty Care		7,181	30,916	27,023	100%		Medford (new clinic)	
Outpatient Mental Health		18,789	20,131	19,584	100%		Medford (new clinic)	
Ancilliary & Diagnostics		42,116	38,169	33,391	100%		Medford (new clinic)	
Research SPACE	N/A		N/A	N/A				
Admin SPACE	N/A		N/A	N/A				
Other SPACE	N/A		N/A	N/A				

Alternate # 2	Dom 100%				**Short description**: Close SORCC at White City; move inpatient programs to Roseburg in VISN 20; include staff relocation options. Move outpatient services to downtown Medford.			
Workload or Space Category	**Baseline Wkld**	**Baseline workload from Millman for beds & stops**	**2012 projected Wkld**	**2022 Projected Wkld**	**% to be transferred**	**Year to begin transfer**	**Receiving Facility Name**	**Receiving Facility % contracted out**
Inpatient Medicine		1	1	1	100%	2004	Medford (new clinic)	100%
Inpatient Surgery		1	-	-	100%	2004	Medford (new clinic)	100%
Inpatient Psych		-	-	-				
Inpatient Dom	727	727	727	727	100%	2008	Roseburg	0
Inpatient NHCU		11	11	11	100%	2004	Medford (new clinic)	100%
Inpatient PRRTP		-	-	-				
Inpatient SCI		-	-	-				
Inpatient BRC		-	-	-				
Outpatient Primary Care		34,705	41,072	33,268	100%		Medford (new clinic)	
Outpatient Specialty Care		7,181	30,916	27,023	100%		Medford (new clinic)	
Outpatient Mental Health		18,789	20,131	19,584	100%		Medford (new clinic)	
Ancilliary & Diagnostics		42,116	38,169	33,391	100%		Medford (new clinic)	
Research SPACE	N/A		N/A	N/A				

Alternate # 3	Dom 100%				**Short description**: Rapid Footprint Reduction - Maintains current programs at White City similar to the initial VISN20 Market Plan. Building demolition occurs on an accelerated timeline with greater space reductions and more aggressive enhanced use leasing.			
Workload or Space Category	**Baseline Wkld**	**Baseline workload from Millman for beds & stops**	**2012 projected Wkld**	**2022 Projected Wkld**	**% to be transferred**	**Year to begin transfer**	**Receiving Facility Name**	**Receiving Facility % contracted out**
Inpatient Medicine		1	1	1	0%			
Inpatient Surgery		1	-	-	0%			
Inpatient Psych		-	-	-				
Inpatient Dom	727	727	727	727	0%			
Inpatient NHCU		11	11	11	0%			
Inpatient PRRTP		-	-	-				
Inpatient SCI		-	-	-				
Inpatient BRC		-	-	-				
Outpatient Primary Care		34,705	41,072	33,268	0%			
Outpatient Specialty Care		7,181	30,916	27,023	0%			
Outpatient Mental Health		18,789	20,131	19,584	0%			
Ancilliary & Diagnostics		42,116	38,169	33,391	0%			

b. <u>Travel Times:</u>

VISN20 includes 23% of the CONUS including 4 states that encompass more geography than any other single network. Implementation of alternatives 1 or 2 would result in a significant decrease of access for veterans residing/traveling from VISN 21. Access for the veterans residing in Northern Oregon and Washington State would be improved. White City's population base is composed largely of special need homeless veterans. These homeless veterans are highly nomadic in nature. However, a recent review of White City's admissions indicate less than 1.5% received services in another Domiciliary within 30 days of admission. Travel times are typically not a compelling issue for homeless veterans seeking help at White City.

Alternate # 1	Name of Facility Being Studied: American Lake							
CARES Category (Dom, Specialty Care or NHCU)	County Name	FY 2012 Workload (BDOC)	Travel time from County to Facility being studied	Workload to be transferred to Facility B	Travel Time from County to Facility B	Workload to be transferred to Facility C	Travel Time from County to Facility C	New weighted Travel Time (calculated)
				American Lake		Medford		
Dom	JACKSON	105,779		92027	5.6 hours			
NHCU	JACKSON	1144				1133	0	
Specialty (new clinic)	JACKSON	14857				14857	0	

Type	Current Access %	New Access %	
Primary Care	72.3	73	No change
Acute Care	55.6	86.6	No Change

= VSSC completed

Alternate # 2	Name of Facility Being Studied: Roseburg							
CARES Category (Dom, Specialty Care or NHCU)	County Name	FY 2012 Workload (BDOC)	Travel time from County to Facility being studied	Workload to be transferred to Facility B	Travel Time from County to Facility B	Workload to be transferred to Facility C	Travel Time from County to Facility C	New weighted Travel Time (calculated)
				Roseburg		Medford		
Dom	JACKSON	105,779		105779	1.7 hours	0		
NHCU	JACKSON	1144				1144	0	
Specialty (new clinic)	JACKSON	14857				14857	0	

Type	Current Access %	New Access %	
Primary Care	72.3	73	No change
Acute Care	55.6	86.6	No Change

= VSSC completed

c. <u>Current physical condition of the realignment site and patient safety:</u>

The White City campus was the hospital portion of Camp White. Camp White was a training site constructed in 1942 for WWII divisions including the 91st and 96th combat divisions. Since becoming a VA facility on February 20, 194, the facility has had as many as 1,300 patients at one time. Sixty-two buildings comprising 894,431 gross square feet (GSF) remain in a cantonment arrangement on the 145-acre site. The occupied buildings have undergone significant renovations over the years and are generally well maintained despite the age. The cantonment arrangement lends itself to a phased replacement of the buildings.

2001 Baseline Data	Name of Facility Being Studied: White City							
Facility Name	Campus Acreage	Original Bed Capacity (Beds)	Number of Vacant Bldgs	Number of Occupied Bldgs	Vacant Space (SF)	Average Condition Score	Annual Capital Costs *	Valuation of Campus (AEW)
White City	145	727	0	62	42,158	2.6	1993	148,000,000

Seismic Issues: White City is one of 16 VA sites with extremely high-risk seismic buildings. The seismic status of the White City bed buildings can be described in relation to the Uniform Building Code (UBC) definitions as either having been designed to Zone 3 requirements for standard occupancy, zone 2B requirements for standard occupancy, or as having no prior seismic upgrades. White City was upgraded from a moderate to high seismic zone in 1994. In 1996 the USGS seismic hazard maps increased the design acceleration from .07g to .5g, which makes the design forces higher in magnitude. The closest active seismic fault is the Sky Lakes Fault Zone 52 miles away. Prior bed building renovations included 130 beds under UBC seismic zone 3 and 260 beds under UBC seismic zone 2B. In addition, Building 211A offers 30 intermediate care beds, which are not a seismic concern.

Since seismic codes are rapidly evolving the current VA Seismic Standards are far more stringent than the codes followed at the time of the prior renovations. Hence, none of the original bed buildings fully comply with current VA seismic criteria and are considered by VA to be in the extremely high risk category. The extremely high risk terminology is somewhat misleading because it really refers to high rise hospitals built prior to 1975 in high risk earthquake zones. Nevertheless, VA has imposed these definitions and requirements on the two story bed buildings at White City. It is questionable whether it is economically viable to strengthen the original White City bed buildings to fully meet VA seismic design standards. Analysis of alternate strengthening schemes as permitted by the June 2002 VA Seismic Design Requirements (Handbook H-18-8) and FEMA 356 are being considered. Engineering staff is optimistic of developing a cost effective strengthening solution for buildings on VA's EHR list.

d. Impact Considerations

Capital: The preferred option presents the lowest capital cost relative to the alternatives.

SUMMARY

Capital Cost Summary	Status Quo (Plus capital)	Original Market Plan	100% Contract	Alt 1	Alt 2	Alt 3
White City						
New Construction	0	14,790,558	3,822,182	0	0	15,141,274
Renovation	0	1,225,175	958,319	0	0	958,319
Leases	0	0	0	0	0	0
Vacant Space Demolition	0	2,094,545	3,400,124	6,663,165	6,663,165	3,911,466
Capital for Status Quo	32,560,000	0	0	0	0	0
TOTAL	32,560,000	18,110,278	8,180,625	6,663,165	6,663,165	20,011,059
Receiving Amer Lake						
New Construction	0	14,548,493	14,548,493	42,511,129	14,548,493	14,548,493
Renovation	0	16,413,369	16,413,369	16,413,369	16,413,369	16,413,369
Leases	0	0	0	0	0	0
Vacant Space Demolition	0	849,528	849,528	849,528	849,528	849,528
Capital for Status Quo	85,083,000	0	0	0	0	0
TOTAL	85,083,000	31,811,390	31,811,390	59,774,026	31,811,390	31,811,390
Receiving Roseburg						
New Construction	0	19,557,493	19,557,493	19,557,493	63,709,024	19,557,493
Renovation	0	4,743,822	4,743,822	4,743,822	4,743,822	4,743,822
Leases	0		0	0	0	0
Vacant Space Demolition	0		1,380,069	1,380,069	1,380,069	1,380,069
Capital for Status Quo	60,136,000		25,681,384	0	0	
TOTAL	60,136,000	24,301,315	51,362,768	25,681,384	69,832,915	25,681,384
Receiving Medford						
New Construction	0	0	0	16,532,612	16,532,612	0
Renovation	0	0	0	0	0	0
Leases	0	0	0	0	0	0
Vacant Space Demolition	0	0	0	0	0	0
Capital for Status Quo	0	0	0	0	0	0
Total	0	0	0	16532612	16532612	0
TOTAL	**177,774,210**	**74,222,983**	**91,354,783**	**108,651,187**	**124,840,082**	**77,503,833**

Operating Costs

In response to the Draft National CARES plan, VISN 20 is including three alternatives to the initial CARES Market Plan for White City. Any shift of beds away from White City will generate a

significant increase in overall operating costs. (The latest DSS figures reveal White City BDOC at $116 compared to the national average at $196. VSSC shows $82.39 per BDOC for White City, $182.66 for American Lake, and $106.55 for Roseburg. VSSC costs include an efficiency factor, which assumes economies of scale). Either cost differential alone would add operating costs to VA of several million dollars per year.

Staff relocation and capital construction costs will also negatively impact the bed relocation alternatives.

The American Lake campus does not have the food preparation capability, nor does it maintain adequate sewage and electrical systems to absorb a bed increase (727) of this magnitude. These types of ancillary support services would also add to the already significant cost and space needed to accomplish service realignment. Similar financial obligations would occur if the White City residential programs were moved to the Roseburg campus, since the Roseburg community has neither the employment opportunities nor the available housing to meet the needs of the many veterans integrating back into the community.

SUMMARY

Operating Cost Summary	Status Quo (Plus capital)	Original Market Plan	100% Contract	Alt 1	Alt 2	Alt 3
White City						
Operating Costs	802,688,257	791,517,427	1,185,887,061	93,000,685	93,000,685	779,763,340
Receiving Am L						
Operating Costs	1,393,315,349	1,215,712,466	1,215,712,464	1,945,238,216	1,215,712,464	1,215,712,464
Receiving Roseburg						
Operating Costs	1,209,100,742	1,040,645,659	1,040,645,657	1,040,645,657	1,507,031,857	1,040,645,657
Receiving New Medford CBOC						
Operating Costs	0	0	0	307,508,216	307,508,216	0
TOTAL	**3,405,104,348**	**3,047,875,552**	**3,442,245,182**	**3,386,392,774**	**3,123,253,222**	**3,036,121,461**
TOTAL Capital Cost	177,774,210	74,222,983	91,354,783	108,651,187	124,840,082	76,123,764
Cost plus Capital	**3,582,878,558**	**3,122,098,535**	**3,533,599,965**	**3,495,043,961**	**3,248,093,304**	**3,112,245,225**

Note: Alternative #1 and #2 do not include costs for site acquisition (5 million) for the Medford clinic or staff relocation costs for moving inpatient beds (10 million).

Old Summary Operating Cost Summary	Status Quo (Plus capital)	Original Market Plan	100% Contract	Alt 1	Alt 2	Alt 3
White City						
Operating Costs	802,679,610	791,517,427	1,185,887,061	93,001,654	93,001,654	779,763,340
Receiving Am L						
Operating Costs	1,393,315,356	1,215,712,466	1,215,712,464	1,905,614,407	1,215,712,464	1,215,712,466
Receiving Roseburg						
Operating Costs	1,209,100,737	1,040,645,659	1,028,711,660	1,028,711,660	1,507,031,857	1,040,645,659
Receiving New Medford CBOC						
Operating Costs	0	0	0	307,508,216	307,508,216	0
TOTAL	**3,405,095,703**	**3,047,875,552**	**3,430,311,185**	**3,334,835,937**	**3,123,254,191**	**3,036,121,465**
TOTAL Capital Cost	177,779	74,222,983	91,354,783	108,651,187	124,840,082	76,123,764
Cost plus Capital	**3,405,273,482**	**3,122,098,535**	**3,521,665,968**	**3,443,487,124**	**3,248,094,273**	**3,112,245,229**

Note: Alternative #1 and #2 do not include costs for site acquisition (5 million) for the Medford clinic or staff relocation costs for moving inpatient beds (10 million).

The above operating costs are a key cost component in calculating Net Present Value, as referred to earlier in this document. A comparison of operating costs for all alternatives is best illustrated using NPV. NPV is a summary of all operating costs and cash flows, inflated and then discounted over time. Though the original market plan alternative has a higher NPV, Alternative #3, Rapid Footprint Reduction, is more appealing than the VISN 20 Market Plan because it has better life cycle costs and it expedites the demolition of all excess space to minimize long-term maintenance costs:

Alternative	NPV
Original Market Plan	460,613,883
100% Contract	76,173,906
Alt 1 – American Lake/Medford	84,190,983
Alt 2 – Roseburg/Medford	331,141,640
Alt 3 – Rapid Footprint Reduction	377,831,030

(NPV Values relative to Status Quo – Higher is Better)

Human Resources

White City does not anticipate prematurely losing providers before any transition of workload is accomplished. Alternative #1 (American Lake) is 430 miles from White City, while the alternative #2 (Roseburg) is 100 miles from White City. It is highly unlikely that any of White City's current employees would commute to Roseburg HCS. The chance for any commute to American Lake is zero. It is estimated that 2/3 of the affected employees would relocate to another VA (potentially 200 of 300 FTEE). At an average estimated relocation cost of $50,000 per employee, this relocation impact is projected at $10,000,000.

Patient Care Issues and specialized programs

Implementing the preferred VISN 20 CARES Plan by keeping the projected residential beds at White City would support patient care and special programs. Goal #1 in the 2003 VA Strategic Plan notes "restore the capability of veterans with disabilities to the greatest extent possible and improve the quality of their lives and that of their families." Objective #1 to that goal reads, "maximize the physical, mental, and social functioning of veterans with disabilities and be recognized as a leader in the provision of specialized health care services." The explanation also states "due to the prevalence of certain chronic and disabling conditions among veterans, VA has developed strong expertise in certain specialized services that are not uniformly available in the private sector." White City VA SORCC provides these specialized services to a needy and disenfranchised veteran population. Four of the eight areas so designated as special emphasis are part of the rehabilitation focus at White City – Serious Mental Illness, Homelessness, Substance Abuse, and Post Traumatic Stress Disorder. Relocation of the White City beds would require the receiving facility to place a high priority on rehabilitation program development.

In one narrow view case scenario, elimination of the SORCC Domiciliary Program will result in veterans being shifted 'up the healthcare continuum' to already overburdened higher and costlier levels of care in both VISN 20 and VHA. In a broader view case scenario, elimination of the SORCC Domiciliary program will create a significant gap in care delivery for this population of homeless patients, leading to any number of negative consequences, such as decreases in veteran's quality of life, lost time from work, increased bed days of care, permanent disability, and death.

In all likelihood, elimination of the Domiciliary Program from the VISN 20 healthcare continuum would result in the broad view scenario above, as this specific level of care and services is not available in the private sector. This has been well documented. For example, for the past twenty years, all President's Commissions examining the provision of Mental Health Services in the United States have cited the huge private sector gap in the availability of biopsychosocial rehabilitation. This lack of private sector services is noted to lead to lives of permanent disability for countless U.S. citizens with otherwise treatable mental illness or substance dependence. Simply put, current SORCC Domiciliary services cannot be purchased in the private sector for our veterans. There is no private sector infrastructure for long-term rehabilitation, and it is too costly to ramp up without assurance that payers will cover this care.

Impact on Research and Academic Affairs

Teaching programs in Social Work, Nursing, Psychiatry, Psychology, Chaplain Service, Dental Hygiene, and Dietetics currently exist. The preferred alternative would keep those long-developed programs viable, working towards appropriate enhancements. Teaching programs could be established at either American Lake or Roseburg, providing the external agencies were available, had capacity ,and were open to collaboration. Moving the inpatient beds would adversely affect the affiliations with Southern Oregon University and Rogue Community College which include Certified Nursing Assistant and Registered Nursing training programs.

Reuse of the Realigned Campus

If the preferred alternative is adopted, White City will continue with its pursuit of appropriate enhanced use lease options for "assisted living" and "single room occupancy" units. The White City facility currently maintains revocable leases with Rogue Community College and Eagle Point High School of over 25,000 square feet. The existing 47-acre golf course would continue to be operated by volunteers with profit of over $50,000/year deposited into general post funds to benefit patients. The Rogue Community College Enhanced Use Lease would occupy another 28 acres of the campus.

Jackson County Mental Health, Jackson County Housing Authority, and private concerns have expressed interest in enhanced use lease opportunities. Assisted living facilities and single resident occupancy initiatives are being considered. These potential leases involve 80 single resident occupancy beds, 50 assisted living beds, and 10 mental health beds and would occupy approximately 57,000 square feet of space.

Summary of alternative analysis

Preferred Alternative description and rationale	The preferred alternative is to use the Rapid Footprint Reduction. White City's economy of scale, well-established therapeutic community, and developed infrastructure, e.g., presence of dining hall, utility systems, all lend to an operation in White City that is clearly more economical and clinically better suited. This option includes a 50% reduction of the facility footprint, decisive and swift demolition and replacement of buildings, stresses enhanced use lease, and expands outpatient services. The financial analysis and quality of care considerations compel VA to endorse this VISN 20 recommended alternative.

	Status Quo	Original Market Plan	100% Contract	Alternate #1	Alternate #2	Alternate #3 **Preferred Option**
Short description	Continue White City as a National Referral Center for Bio-psychosocial rehabilitation at 727 Beds	Maintain White City residential beds based on CARES projections for VISN20 (plus Northern California and Nevada) and expand outpatient services	Considers cost to contract for inpatient care. Bio-psychosocial rehabilitation not available in private sector	Close White City Campus and relocate all residential beds to American Lake. Move Outpatient services to new clinic in Medford	Close White City Campus and relocate all residential beds to Roseburg. Move Outpatient services to new clinic in Medford	Maintains current programs at White City similar to the initial VISN20 Market Plan. Building demolition occurs on an accelerated timeline with greater space reductions and more aggressive enhanced use leasing.
Total Construction Costs	177,779	74,222,983	91,354,783	108,651,187	124,840,082	77,503,833
Life Cycle Costs	3,582,878,558	3,122,264,675	3,506,704,652	3,498,687,575	3,251,736,918	3,111,725,527

	Status Quo	Original Market Plan	100% Contract	Alternate #1	Alternate #2	Alternate #3 **Preferred Option**
Impact on Access	Close to Interstate 5 corridor, which facilitates west coast, access from both north and south. Medford is halfway between Sacramento/ San Francisco and Portland. Veterans present for care from across the region, often without a referral from another VAMC	Patients from VA facilities across VISN20 are admitted to White City using state of the art electronic referral process. VISNs 19 and 21 would continue to be served by White City	Veterans cannot access Bio-psychosocial rehabilitation through contract venues.	Access mainly limited to Washington State.	Roseburg is 98 miles north of the White City/Medford area. Roseburg does not have an airport nor the urban population base and employers that the Medford area offers. Rural community without the depth and breadth of medical resources found in more urban centers	Patients from VA facilities across VISN20 are admitted to White City using state of the art electronic referral process. VISN 19 and 21 would continue to be served by White City
Impact on Quality	Retain high outcomes and patient satisfaction at low cost per BDOC	Retain high outcomes and patient satisfaction at low cost per BDOC	If contractor found, no guarantee of measurement or performance	Quality could be maintained assuming Bio-psychosocial rehabilitation is a top facility priority	Quality could be maintained assuming Bio-psychosocial rehabilitation is a top facility priority	Retain high outcomes and patient satisfaction at low cost per BDOC
Impact on Staffing and Community	Maintains staffing levels and community partnerships	Maintains staffing levels and community partnerships	If contractor found, unknown staffing and loss of therapeutic community at SORCC	Cost to relocate staff, disruption of clinical programs, loss of significant community partners in Southern Oregon	Cost to relocate staff, disruption of clinical programs, loss of significant community partners in Southern Oregon.	Maintains staffing levels and community partnerships
Impact on Research and Education	Maintains affiliations with Rogue Community College and Oregon Health Sciences University	Maintains affiliations with Rogue Community College and Oregon Health Sciences University	Unknown	Lose affiliation with Rogue Community College and local Nursing training and recruitment initiatives	Lose affiliation with Rogue Community College and local Nursing training and recruitment initiatives.	Maintains affiliations with Rogue Community College and Oregon Health Sciences University

	Status	Original Market Plan	100% Contract	Alternate #1	Alternate #2	Alternate #3
Optimizing Use of Resources	White City 2003 BDOC = $116/day versus national average of $196/day. CARES BDOC projection = 252,373/year	White City 2003 BDOC = $116/day versus national average of $196/day. CARES BDOC projection = 252,373/year	CARES Medicare rate is higher than White City per BDOC understanding no private sector equivalent exists	At national average cost per BDOC, this option would cost VA an additional 20 million/year for same BDOC	At national average cost per BDOC, this option would cost VA an additional 20 million/year for same BDOC	Converts dollars being used to maintain vacant space to patient care.
Support other Missions of VA	White City and Eagle Point National Cemetery CWT partnership	White City and Eagle Point National Cemetery CWT partnership	Unknown	May be opportunities	May be opportunities	White City and Eagle Point National Cemetery CWT partnership
Other significant considerations	According to UCR-1 (Cost efficiency), White City is second best in VA, second only to Manila in adjusted facility work accomplished Testimony at CARES hearing supports inpatient presence remains at White City.	According to UCR-1 (Cost efficiency), White City is second best in VA, second only to Manila in adjusted facility work accomplished Testimony at CARES hearing supports inpatient presence remains at White City.	Last two President Commissions cited dearth of Biopsychosocial rehabilitation in the country. Jackson County mental health indicates severe shortage of services in Oregon. Services White City provides are not available in the community.	Would require Major Construction project in excess of 30 million dollars. American Lake is a higher seismic risk zone than White City	Would require Major Construction project in excess of 30 million dollars. Less employment services for veterans.	According to UCR-1 (Cost efficiency), White City is second best in VA, second only to Manila in adjusted facility work accomplished Testimony at CARES hearing supports inpatient presence remaining at White City.